



Original Research Article

PERCEIVED HEALTHCARE ACCESS AND SERVICE QUALITY AMONG INTERNAL MIGRANT WORKERS AT THEIR HOST TOWN VERSUS HOME TOWN: A CROSS-SECTIONAL COMPARATIVE STUDY FROM DAHOD DISTRICT, GUJARAT, INDIA

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ABSTRACT

Background: Internal migrant workers frequently move between their host town (place of work) and home town (place of origin) for work purpose, and their access to and perception of healthcare may differ substantially between these two settings. Evidence directly comparing the two settings within the same individuals is limited in India. **Objectives:** To compare the perceived quality, access, affordability and availability of healthcare services experienced by internal migrant workers at their host town versus their home town, and to describe their sociodemographic profile and health-insurance coverage.

Materials and Methods: A community-based, cross-sectional comparative study was conducted among 253 internal migrant workers originating from the Dahod–Katwara area of Dahod district, Gujarat, India. Data were collected using a pre-tested, structured questionnaire capturing distance, travel time, facility type, service availability, and Likert-type ratings of quality, staff availability, cleanliness and affordability for both settings. Within-subject (paired) comparisons used the Wilcoxon signed-rank test for ordinal ratings and the McNemar test for dichotomous service availability; $p < 0.05$ was considered significant.

Results: Participants had a mean age of 37.6 ± 10.5 years; 187 (73.9%) were male, 154 (60.9%) had primary or no formal education, and the median monthly income was ₹15,000. Only 15 (5.9%) had any health insurance. Compared with the home town, the host town was rated significantly higher for quality of services (mean 3.44 vs 3.19), staff availability (3.65 vs 3.48) and cleanliness (3.22 vs 3.04) (all $p < 0.001$), and offered markedly greater availability of specialist (28.9% vs 6.5%) and diagnostic services (41.4% vs 14.2%) (both $p < 0.001$). Conversely, the home town was rated significantly more affordable (3.78 vs 3.57, $p < 0.001$) and facilities were closer ($p = 0.005$) and quicker to reach ($p = 0.002$). On direct comparison, 40.5% felt standards were about the same, 32.9% favoured the home town and 26.6% favoured the host town.

Conclusion: Migrant workers experience a clear trade-off between the two settings: host towns offer higher perceived quality and better specialist and diagnostic services, whereas home towns offer greater affordability and proximity. In the near-absence of insurance, portable financial protection and migrant-sensitive services are needed to ensure continuity of care.

Keywords: internal migrants; migrant workers; healthcare access; health services accessibility; affordability.

INTRODUCTION

Internal migration is one of the most important demographic and economic processes in contemporary India. Successive rounds of the Census and large-scale surveys have documented that hundreds of millions of Indians live away from their place of birth, and a substantial proportion move specifically for work. Migrant workers are concentrated in unorganised sectors such as construction, agriculture, textiles, small-scale manufacturing and services, where employment is often informal, seasonal and poorly protected. While migration can raise household income and expand livelihood opportunities, it also creates distinctive health vulnerabilities arising from hazardous occupations, crowded and unsanitary living conditions, weak social support and, importantly, discontinuities in access to health care.^[1]

A defining feature of the migrant worker's life is that health care is sought across two very different settings. The host town — typically a larger town or industrial cluster — is where the worker spends most of the year and earns a living, but where care may be delayed or avoided because of cost, unfamiliarity, language barriers, discrimination or ignorance of available services. The home town — usually a rural or semi-urban native place — is visited periodically, and it is there that many workers prefer to consult familiar providers, often accompanied by family. This bifurcation of care-seeking can fragment the management of acute illness and, more seriously, of chronic conditions such as hypertension, diabetes and tuberculosis, leading to delayed diagnosis, poor follow-up and avoidable out-of-pocket expenditure.^[2]

Much of the existing Indian literature on migrant health has focused on occupational hazards, communicable diseases, maternal and child health, or nutrition. Comparatively few studies have directly compared how the same migrant workers perceive and use health services in their host town versus their home town. Understanding where migrants feel care is better, cheaper or more accessible — and where it falls short — can help target scarce programme resources more effectively.

Against this background, the present study was undertaken among internal migrant workers originating from the Katwara village of Dahod district, Gujarat, with the following objectives: (i) to describe the sociodemographic profile and health-insurance coverage of the participants; (ii) to compare access (distance, travel time, facility type), perceived quality, staff availability, cleanliness, affordability and service availability of health care between the host town and the home town; and (iii) to elicit workers' overall comparative perception of healthcare standards across the two settings.

MATERIALS AND METHODS

2.1 Study design and setting

This community-based, cross-sectional, comparative study was conducted among internal migrant workers originating from Katwara village and surrounding villages of Dahod district, Gujarat, India, who were employed at various destination locations within and outside Gujarat. The host locations were heterogeneous with respect to the degree of urbanization and availability of healthcare infrastructure. Data were collected over a period of one year. (*November 2024 to October 2025*)

2.2 Study population and eligibility criteria

Adult migrant workers (≥ 18 years) were eligible if they had migrated from their native home town to a host town for the purpose of work, had stayed at the host town for at least 12 months, and had visited their home town at least once in the preceding 6 months. Workers who were acutely and severely ill at the time of the survey, or who declined to provide informed consent, were excluded.

2.3 Sample size and sampling technique

A total of 253 migrant workers were enrolled. The sample size was based on the expected difference in perceived healthcare standards between host and home settings, assuming a 95% confidence level and 80% power, with an additional allowance for non-response. Participants were recruited from worksites and residential clusters using convenience sampling.

2.4 Data collection tool

Data were collected using a pre-tested, structured, interviewer-administered questionnaire in the local language. The instrument comprised four sections: (a) sociodemographic details (age, sex, education, occupation, monthly income, health-insurance status); (b) healthcare characteristics at the host town; (c) the corresponding characteristics at the home town; and (d) a direct comparative question. For each setting, the questionnaire recorded the type of nearest facility, distance, usual mode of travel, travel time, the services available, frequency of use, and Likert-type ratings of the quality of services, satisfaction with availability of medical staff, cleanliness and hygiene, and affordability. Ordinal responses were scored on a five-point scale (1 = lowest to 5 = highest) for analysis.

2.5 Operational definitions

Migrant worker: a person who had moved from their usual place of residence (home town) to another town (host town) for work and had stayed there for more than 12 months.

Host town: The current place of residence and work was recorded as either a single or multiple host locations.

Home town: the native place where the worker's family usually resides and which the worker visits periodically.

Perceived healthcare standard: the participant's subjective rating of care across the domains of quality, staff availability, cleanliness and

affordability, measured on the five-point scales described above.

2.6 Statistical analysis

Data were entered and cleaned in Microsoft Excel and analysed using Epi Info 7. Continuous variables were summarised as mean $\pm$ standard deviation (SD) or median with interquartile range (IQR), as appropriate, and categorical variables as frequencies and percentages. Because each participant provided paired responses for the host and home settings, within-subject comparisons were performed: the Wilcoxon signed-rank test was used for ordinal (Likert) ratings and ordered categorical variables (distance and travel-time bands), and the McNemar test for the presence or absence of individual services. The effect size r ($Z / \sqrt{n}$) is reported for the Wilcoxon tests. A two-sided p -value < 0.05 was considered statistically significant.

2.7 Ethical considerations

Ethical approval was obtained from the Institutional Ethics Committee of Zydus Medical college and Hospital (12/2024). Written informed consent was obtained from every participant before data collection, participation was voluntary, and confidentiality and anonymity were maintained throughout.

RESULTS

3.1 Sociodemographic profile

A total of 253 internal migrant workers participated. Their mean age was 37.6 ± 10.5 years (range 18–70 years), with the largest group (45.8%) aged 30–39 years. Most participants were male (187, 73.9%). Educational attainment was low: 80 (31.6%) had no formal education and 114 (45.1%) had studied only up to the primary level, so that 154 (60.9%) had primary schooling or less. Agriculture and manual labour dominated the occupational profile — farmers/agricultural workers (32.5%), construction workers (15.1%) and general labourers (15.1%) together accounted for almost two-thirds of the sample. The median monthly income was ₹15,000 (IQR ₹10,400–₹18,000), and 79.1% earned less than ₹20,000 per month. Strikingly, only 15 participants (5.9%) reported having any form of health insurance, and of these, insurance covered most medical expenses for only a minority. The full profile is presented in Table 1.

Table 1: Sociodemographic characteristics of the internal migrant workers (N = 253)

Characteristic	n	%
Age group (years)		
18–29	48	19.1
30–39	115	45.8
40–49	48	19.1
≥ 50	40	15.9
Sex		
Male	187	73.9
Female	66	26.1
Education level		
No formal education	80	31.6
Primary	114	45.1
Secondary	43	17.0
Higher secondary	11	4.3
Graduate and above	5	2.0
Occupation		
Farmer / agricultural worker	82	32.5
Construction worker	38	15.1
Labourer	38	15.1
Factory worker	15	6.0
Shopkeeper / business	11	4.4
Other (driver, tailor, carpenter, sweeper, etc.)	69	27.3
Monthly income (₹)		
$< 10,000$	36 ^a	15.7
10,000–19,999	146 ^a	63.5
$\geq 20,000$	48 ^a	20.9
Health insurance		
Any (full or partial)	15	5.9
None	235	92.9

^a Income percentages calculated among 230 respondents who reported an interpretable income; median ₹15,000 (IQR ₹10,400–₹18,000). Three respondents did not answer the insurance question.

3.2 Access and structural characteristics of care

The nearest facility differed structurally between the two settings. In the home town, three-quarters (75.1%) of workers were served primarily by a Primary Health Centre (PHC), whereas in the host town a larger share had a hospital nearby (34.1% vs 15.0%). Facilities in the home town were, on balance,

closer and quicker to reach: 24.3% lived within 1 km at home versus 17.0% at the host town (Wilcoxon $p = 0.005$), and 45.5% could reach care in under 15 minutes at home versus 34.6% at the host town ($p = 0.002$). Public transport was the commonest mode of travel in both settings but was relied upon more heavily in the host town (57.9% vs 40.3%), while

walking was more frequent in the home town (19.8% vs 7.9%). The frequency of facility use was almost identical across settings, with roughly 69% visiting

“occasionally (a few times a year)” in each. These findings are summarised in Table 2.

Table 2: Access and structural characteristics of the nearest healthcare facility at the host town versus home town

Characteristic	Host town %	Home town %	p-value ^b
Nearest facility type			
Primary Health Centre	61.6	75.1	—
Hospital	34.1	15.0	—
Clinic / Other	4.4	9.8	—
Distance to facility			0.005
< 1 km	17.0	24.3	
1–5 km	53.7	55.4	
5–10 km	28.4	18.3	
> 10 km	0.9	2.0	
Travel time to facility			0.002
< 15 min	34.6	45.5	
15–30 min	53.1	45.8	
30–60 min	11.8	6.3	
> 1 hour	0.4	2.4	
Usual mode of travel			—
Public transport	57.9	40.3	
Private vehicle	25.0	28.9	
Walking	7.9	19.8	
Bicycle	9.2	10.7	

^bWilcoxon signed-rank test for ordered distance and travel-time bands. “—” = descriptive only.

3.3 Perceived quality, staffing, cleanliness and affordability

On the four ordinal quality domains, a consistent pattern emerged (Table 3, Figure 1). The host town was rated significantly higher than the home town for quality of services (mean 3.44 ± 0.77 vs 3.19 ± 0.83 ; $Z = -3.93$, $p < 0.001$, $r = 0.41$), satisfaction with availability of medical staff (3.65 ± 0.61 vs $3.48 \pm$

0.60 ; $Z = -3.54$, $p < 0.001$, $r = 0.41$) and cleanliness and hygiene (3.22 ± 0.72 vs 3.04 ± 0.73 ; $Z = -3.49$, $p < 0.001$, $r = 0.44$). The direction reversed for affordability, which was rated significantly better in the home town (3.78 ± 0.65 vs 3.57 ± 0.73 ; $Z = -3.87$, $p < 0.001$, $r = 0.47$): 73.4% rated home-town care affordable or very affordable, compared with 58.1% for the host town.

Table 3: Perceived healthcare domains at the host town versus home town (five-point scales; paired Wilcoxon signed-rank test)

Domain (1–5)	Host mean (SD)	Home mean (SD)	Z	p-value	r
Quality of services	3.44 (0.77)	3.19 (0.83)	-3.93	< 0.001	0.41
Availability of medical staff	3.65 (0.61)	3.48 (0.60)	-3.54	< 0.001	0.41
Cleanliness and hygiene	3.22 (0.72)	3.04 (0.73)	-3.49	< 0.001	0.44
Affordability	3.57 (0.73)	3.78 (0.65)	-3.87	< 0.001	0.47

Higher scores denote better perceived quality, staffing, cleanliness and affordability. $n = 227$ – 229 complete pairs per domain.

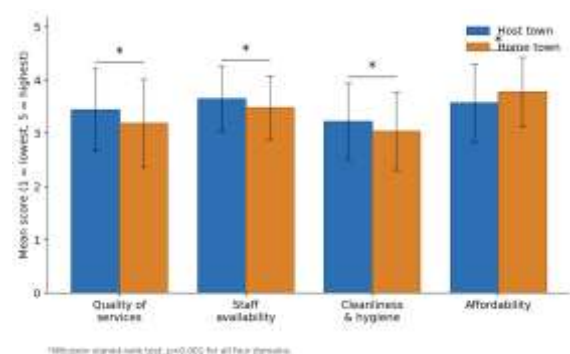


Figure 1: Mean perceived scores ($\pm$ SD) for four healthcare domains at the host town versus home town. The host town scored significantly higher for quality, staff availability and cleanliness, whereas the home town scored higher for affordability (Wilcoxon signed-rank test, $p < 0.001$ for all four domains).

3.4 Availability of specific services

General consultation, maternity care, vaccination and pharmacy services were widely and comparably available in both settings (each reported by roughly 85–99% of workers, with no significant host–home difference). The gap was concentrated in higher-level services. Specialist services were reported by 28.9% of workers at the host town versus only 6.5% at the home town, and diagnostic services (e.g. X-ray, laboratory) by 41.4% versus 14.2% — differences that were large and highly significant (McNemar $p < 0.001$ for both). Emergency services (76.3% vs 69.8%, $p = 0.037$) and child healthcare (78.4% vs 64.7%, $p < 0.001$) were also more often available at the host town. Table 4 and Figure 2 present these results.

Table 4: Availability of specific healthcare services at the host town versus home town (McNemar test for paired proportions)

Service	Host town %	Home town %	p-value
General consultation	98.3	99.1	0.683
Emergency services	76.3	69.8	0.037
Maternity care	92.7	89.7	0.248
Child healthcare	78.4	64.7	< 0.001
Vaccination	90.1	88.4	0.556
Specialist services	28.9	6.5	< 0.001
Diagnostic services (X-ray, lab)	41.4	14.2	< 0.001
Pharmacy	87.1	85.8	0.579

Percentages calculated among 232 workers with complete paired data on service availability.

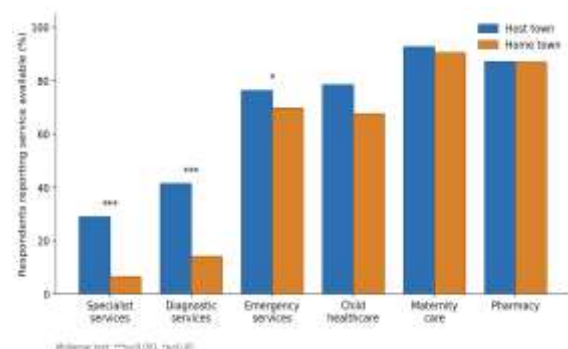


Figure 2: Availability of selected healthcare services at the host town versus home town. Specialist and diagnostic services were far more available at the host town (McNemar * $p < 0.001$), as were emergency services (* $p < 0.05$); basic services showed no significant difference.**

3.5 Overall comparative perception

When asked to directly compare healthcare standards in their home area (Katwara/Dahod) with those in their host town ($n = 222$ responded), 40.5% felt standards were about the same. A slightly larger share favoured the home town (32.9% rated it slightly or much better) than the host town (26.6% rated it slightly or much better) (Figure 3). This near-even split is consistent with the domain-level findings, in which each setting had distinct advantages — the host town on quality and specialist services, the home town on affordability and proximity.

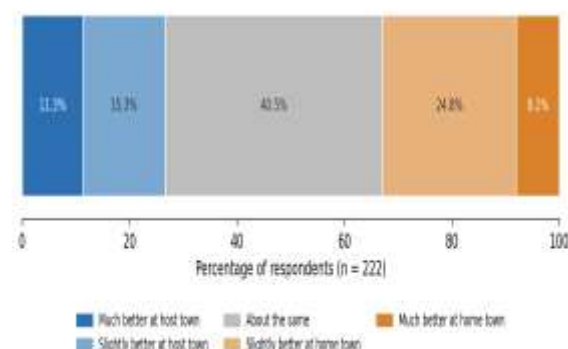


Figure 3: Migrant workers' overall comparison of healthcare standards in their home town (Katwara/Dahod) versus their host town ($n = 222$). Responses were roughly balanced, with a plurality perceiving the two settings as comparable.

DISCUSSION

This study compared, within the same individuals, how internal migrant workers from a district of Gujarat perceive and use health care in their host town versus their home town. The central finding is one of trade-off rather than uniform advantage. The host town was consistently rated higher on the quality of services, availability of medical staff and cleanliness, and offered far greater access to specialist and diagnostic services. The home town, in contrast, was perceived as more affordable and its facilities were closer and quicker to reach. On an overall, direct comparison, workers were almost evenly divided, with a plurality regarding the two settings as broadly similar.

These patterns are internally coherent and align with the underlying geography of the Indian health system. Host towns, being larger and more industrialised, concentrate hospitals, specialists and diagnostic infrastructure, which plausibly drives the higher ratings for quality and the substantially greater availability of specialist and diagnostic care. That same concentration in the private and secondary/tertiary sector, however, tends to raise the cost of care, which is reflected in the poorer affordability rating for the host town. Home towns, served predominantly by Primary Health Centres, offer lower-cost, nearer and more familiar care but with a narrower range of services — the classic urban–rural contrast between accessibility of advanced services and affordability of primary care. The sociodemographic profile underlines the vulnerability of this population. A workforce that is predominantly educated to primary level or below, employed in agriculture and manual labour, and earning a median of ₹15,000 per month has limited financial resilience against health shocks. The most striking finding in this respect is that fewer than one in sixteen workers (5.9%) had any health insurance. In a setting where higher-quality care in the host town is also the more expensive care, the near-total absence of financial protection is likely to push workers either to defer care or to travel back to their home town for treatment — an implicit rationing of care by cost and geography that fragments continuity, particularly for chronic disease.

These findings are consistent with the broader Indian and global literature on migrant health, which repeatedly identifies affordability, lack of insurance

or non-portability of entitlements, unfamiliarity with local services, language barriers and fear of discrimination as key obstacles to care at the destination. The present study adds value by measuring both settings within the same respondents, allowing the advantages and disadvantages of each to be quantified directly rather than inferred from separate populations.

From a health-systems and policy standpoint, the results point to several priorities. First, financial protection must be made genuinely portable: schemes such as Ayushman Bharat–PM-JAY and State insurance programmes should function seamlessly across districts and States so that a worker can obtain cashless or subsidised care wherever they fall ill, and coverage among informal migrant workers — currently negligible in this sample — must be actively expanded. Second, host towns need migrant-sensitive services, such as worksite outreach clinics, mobile health units, extended clinic hours and multilingual staff or interpreters, to lower the practical barriers that deter workers from using nearby facilities. Third, continuity of care for chronic conditions (hypertension, diabetes, tuberculosis) should be safeguarded through portable health records and referral linkages between host- and home-district facilities. Strengthening diagnostic and specialist capacity at PHC/CHC level in migrant-sending areas would also reduce the need for costly travel.

4.1 Limitations

The outcomes are self-reported perceptions and are therefore susceptible to recall and social-desirability bias; they were not corroborated by objective indicators such as facility audits or clinical outcomes. Second, the study was conducted among migrants originating from a single district which limits generalisability to all Indian migrant workers. Third, host towns were heterogeneous and were not disaggregated in this analysis, so setting-specific effects could not be examined.

CONCLUSION

Host towns offer higher perceived quality and substantially better specialist and diagnostic services, whereas home towns offer greater affordability and proximity; on balance, workers regard the two as broadly comparable.

In a population that is economically vulnerable and almost entirely without health insurance, this trade-off translates into a real risk of delayed or fragmented care.

Ensuring portability of health entitlements, expanding financial protection for informal migrant workers, and establishing migrant-sensitive services at the destination are essential steps toward equitable and continuous health care for this important segment of the workforce.

Declarations

Ethics approval and consent to participate:

Obtained from the Institutional Ethics Committee, written informed consent was obtained from all participants.

Consent for publication: Not applicable (no individually identifiable data are presented).

Availability of data and materials: The dataset analysed during the current study is available from the corresponding author on reasonable request.

Conflicts of interest: The authors declare that they have no conflicts of interest.

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